April 1, 2011

Re: Aetna Life Insurance Co.
Aetna Tracking Numbers: CA-2010-11, CA-2010-12
State Tracking Numbers: PF-2010-02367, PF-2010-02396

Responses to the questions provided on March 21, 2011 are discussed below. Responses to items 19d, 20, and 23 remain outstanding. We continue to review these questions and expect to provide responses during the week of April 4th.

1. **Response previously provided.**

2. **Response previously provided.**

3. **Response previously provided.**

4. **Response previously provided.**

5. **Response previously provided.**

6. **Response previously provided.**

7. **Response previously provided.**

8. **Response previously provided.**

9. **Development of Annual Rate Increase Percentage** (from the Certification): The rate increase for members renewing between 4/1/2011 and 6/30/2011 is based on data (5/9 – 4/10) used for an earlier rate filing. This is not acceptable (Exhibit C-2).

   On Dec. 10, 2010, in its finding that Aetna's rate filing PF-2010-01397 was unacceptable, the Department observed that "assumption of a set trend increase out into the future is inconsistent with the medical loss ratio requirements of 10 Cal. Code Reg. 2222.12."

   Revise Exhibit C-2 in Excel to reflect a more recent experience period. Where the value of a cell is not given by a formula, the source of the value should be explained. **We are providing the exhibit used to support the filing for July 1, 2011 effective dates with the requested modifications. Please note that the premium at current rates (Step 7) assumes that the rate increase proposed for April 1, 2011 was implemented on April 1, 2011. This exhibit further supports the need for an additional increase beginning July 1, 2011.**

   The revised exhibit is found on the 'Rate Development' tab of Exhibit C-2 2011-07.xls

10. **Development of Annual Rate Increase Percentage** (from the Certification): The midpoints of the experience and rating periods should be determined by weighting the months in the periods according to membership. The revised Excel exhibit should reflect this change.
The revised exhibit reflects this change. The calculation of the mid-points is detailed on the "Midpoint Calculation" tab.

11. **Response previously provided.**

12. **Durational Factors** (from the Certification): Provide one or more exhibits in Excel showing how the various durational factors were derived.
Duration factors are derived from Table III-3a of an SOA-Milliman study on duration in individual medical insurance (http://www.soa.org/files/pdf/IH%20Durational%20Study_Final%201006.pdf) by applying an 80% adjustment to the original slope and further smoothing the ultimate duration factor. The curve for deductibles up to $1000 is used for the projection of first dollar plans; the curve for deductibles over $1000 is used for the other two projections.
Member months by duration year are used to determine the average duration factor for each projection period. The change in duration factors between periods is applied as a multiplicative adjustment to incurred claims. Please see the "Duration Factor Calc" tab for details on how the duration adjustment is calculated.

13. **Annual Rate (from the California Rate Filing Form): To the two columns now in** the exhibit (CARFF Item #10), add a third titled "Change in Annual Premium Rate"
Updated exhibits have been provided showing the percentage change in the annual premium rates.

14. **Rate increases for average member over 48 months, by entry date.** See attached template. Fill out assuming 4/1/11 implementation of the rate filing increases.
The template has been updated as requested.

15. **Enrollment summary.** Provide total monthly member enrollment of all Individual policies from 1/2006 forward by closed block and open block. Show separately enrollment for policies exempt from PPACA requirements and policies under the supervision of DMHC. Show historical sales and lapses.
Please see the "15-Enrollment Summary" tab in the accompanying file "Exhibits2 for 03-21 CDI Questions.xls". Note that Aetna Life Insurance Company does not have any Individual policies under the supervision of the DMHC.

16. **Attribution Analysis.** For each product, identify the components of the filed rate change according to the following sources:
    a. Actual to expected claim experience during base period of new rate filing,
    b. Secular trend (detail below),
    c. Leveraging

d. Average length of projection period used to calculate trend,
e. Risk / demographic change (detail below)

For all products:

The 2.8% quarterly increase for the April 1, 2011 filings is due to secular trend. The 15.6% aggregate increase for the July 1, 2011 filing is due to secular trend (12.4%), leveraging (0.1%), and an adjustment (3.1%) to reflect actual experience that has been worse than expected. Note that we are assuming this rate change will be effective 12 months after the last annual rate increase was intended to take effect. We assume risk / demographic changes will impact claims and premium equally; hence, this does not factor into the proposed rate change.

17. Secular Trend Detail

a. For trend from CY2010 to 2011, show pmpm cost and utilization breakout by aggregate benefit category, i.e. hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe)(SB1163, SEC. 7. 10181.3(b)(18)).

Please see the "17-Secular Trend" tab in the accompanying file "Exhibits2 for 03-21 CDI Questions.xls". Note that this exhibit also contains the detail requested in part c.

b. State the degree of credibility of experience data used in estimating medical trend inflation.

Individual experience is assigned 0% credibility for developing estimates of trend. Aetna develops medical trend estimates based on fully insured group PPO data and projections for the associated market(s). In California, group trends are developed separately for Northern California, Southern California other than San Diego, and San Diego. These trends are developed by aggregate benefit category. The group trends are then weighted based on the historical distribution of Individual costs by aggregate benefit category and market. A further adjustment is made to reflect the impact of deductible leveraging in determining the final trend assumption to use in pricing our Individual business.

Aetna prefers to use group experience to develop estimates of medical trends for the following reasons:

1. **Group fully-insured PPO membership in California averaged approximately 191,000 members in 2008, 226,000 members in 2009, and 241,000 in 2010. Corresponding individual membership was approximately 46,000 members in 2008, 59,000 members in 2009, and 67,000 members in 2010.**
2. **Given the rapid growth of our individual block and challenges inherent in normalizing experience for changes due to demographic, benefit, and duration mix, we feel using the group business which is much more stable provides a cleaner, more-reliable trend estimate.**

c. Show the same breakout for trend from CY2009 to 2010, and CY2008 to 2009.

d. For CY2010 to 2011, further allocate cost and /or utilization trends by pure inflation and change in mix of services
Unit cost projections are based on an analysis of provider contracts and represent estimates of the cost of inflation in provider rates. The impact of changes in the mix of services is implicitly reflected in the projected utilization trends. Utilization trends tend to be fairly volatile from year to year at the benefit category level, particularly when considering the size and immaturity of Aetna's individual business. As such, we develop utilization trends with a focus on the resulting trend assumptions and the reasonableness of these aggregate assumptions in relation to recent trend experience at a national level. Projected utilization trends are intended to account for changes in mix of services but we are unable to split the projections into components that are more refined than total assumed utilization change by aggregate benefit category.

18. **Risk / demographic change.** Show detail for cost and utilization changes within the plan population due to changes in gender mix, average age, duration, internal plan mix, inter-plan mix, and any other relevant variables.
Aetna entered the individual health market in California in July 2005. While we have attempted to perform internal estimates of the impact of changes in mix on net claims costs, these estimates are typically performed at a national level and have not been reviewed in light of recent experience. We also do not calculate the impact of mix on utilization. Due to the challenges of thoroughly understanding mix and how it impacts medical costs as well as the rapidly-changing profile of our individual business, we have opted to rely on group experience and cost projections to develop trend assumptions which are then used to develop pricing for our individual business.

19. **Contractual Increases**
    a. Provide an exhibit showing the contractual increases for 2011 by rating area for inpatient and outpatient services. Show the weights assigned to each increase.
    Please see the "19a-Facility Contract Increases" tab in the accompanying file "Exhibits2 for 03-21 CDI Questions.xls".
    b. For each type of inpatient service (medical, surgical etc) in 2009 and 2010, show days pmpy, cost per patient per day, and the associated trends, including the breakout between trend in unit cost and utilization / mix. Calculate the total mix shift.
    Please see the "19bc-Facility Trend Detail" tab in the accompanying file "Exhibits2 for 03-21 CDI Questions.xls".
    c. For each type of outpatient service (ER, surgical etc) in 2009 and 2010, show days pmpy, cost per patient per day, and the associated trends, including the breakout between trend in unit cost and utilization / mix. Calculate the total mix shift.
    Please see the "19bc-Facility Trend Detail" tab in the accompanying file "Exhibits2 for 03-21 CDI Questions.xls".

d. What actions has Aetna taken in the interest of policyholders to ensure the lowest negotiated prices from hospitals and out-patient facilities?
A response will be provided during the week of April 4th.

20. Drivers of Medical Trend

a. Describe the significant economic, social and medical developments that have been driving Aetna's *in-patient* price inflation in the recent past. For each of these developments, explain at what level it should reasonably be expected to continue in future, and why.
b. Describe the significant economic, social and medical developments that have been driving Aetna's *out-patient* price inflation in the recent past. For each of these developments, explain at what level it should reasonably be expected to continue in future, and why.
c. Describe the significant economic, social and medical developments that have been driving Aetna members' increasing utilization in the recent past. For each of these developments, explain at what level it should reasonably be expected to continue in future, and why.
d. Describe whether and how the independent actuary (Milliman) has independently observed these medical trends and whether it includes them in its pricing model.
A response will be provided during the week of April 4th.

21. Response previously provided.

22. Lifetime Loss Ratios. Provide and justify the key assumptions used to derive lifetime loss ratio (LLR) estimates for the various products. In particular, show how the LLR projections are based on the durational factors in item #11 above.
Please see "LLR Assumption Detail for 2Q11 IVL Filing.pdf" for a discussion of the key assumptions. The calculation of the underwriting wear-off adjustments from the durational factors is illustrated in the "22-UW Wear-Off Calc" tab of "Exhibits2 for 03-21 CDI Questions.xls".
Note that the claims for 8/10-12/10 are projected in two pieces – members effective prior to 8/10 and new sales during 8/10-12/10. The underwriting adjustment shown in Exhibit C of the rate filing is for the projection of claims on existing business. New business claims are the existing business claims multiplied by the ratio of the Year 1 durational factor to the average durational factor for existing business and produces a result roughly comparable to performing a single projection using the change in the durational factor when considering sales during the projection period.

23. Medical Loss Ratio per PPACA. In addition to lifetime loss ratio estimates, we require a Medical Loss Ratio (MLR) exhibit according to the guidance issued by the Department of Health and Human Services (HHS) on 11/18/2010. The MLR exhibit should show by month actual 2010 experience and the prospective experience in 2011 of the market segment relevant to plans being filed **(i.e., all individual plans, including those not included in the current filing).** Experience includes breakouts by enrollment, incurred claims and earned premium. Breakouts should also be by

open block, closed block and non-PPACA. All individual plans will be aggregated for the purposes of MLR calculation, and the MLR will be calculated in accordance with the HHS regulation.

A response will be provided during the week of April 4th.

24. Additional information required per draft Guidance 1163:2. Provide the following per Section A of the draft Guidance for: Aetna Life Insurance Company, its California health business, and the Individual medical block in California

a. For 2008, 2009 and 2010: the post-tax statutory net income, statutory capital and surplus, and RBC authorized control level according to the Annual Statement of the Aetna Life Insurance Company.

b. The anticipated post-tax statutory net income, statutory capital and surplus, and RBC authorized control level anticipated for the company in 2011.

For Aetna Life Insurance Company:

($ Millions)

Year	Net Income	Capital and Surplus	Authorized Control Level Risk-Based Capital
2008	$ 951.2	$ 3,743.5	$ 552.0
2009	882.6	4,858.2	651.5
2010	1,193.1	4,182.4	572.6
2011 Forecast	1,088.0	4,691.0	563.6

For the California health business:

This information is not currently available. We will be able to provide 2010 actual values after the 1Q11 NAIC quarterly statements are completed and filed.

For the California Individual medical block:

Aetna is not required to prepare this information for reporting purposes. As such, the requested detail is not available.

25. Additional information required per draft Guidance 1163:2. Provide the following per Section A of the draft Guidance:

a. The annual compensation of each of the 10 most highly paid executives of both the insurer submitting the rate filing and the parent corporation / ultimate controlling party of that insurer.

Information for the parent corporation (Named Executive Officers) will be provided after the 2011 Proxy Statement is filed (expected filing date is April 11, 2011).

26. Additional information required per draft Guidance 1163:2. In your comments for the CA Plain-Language Rate Filing Description, you have stated that "cost as a percentage of Medicare is not currently available but estimates can be provided at a future date upon request." We are now making that request. When will these estimates be available?

Aetna can provide estimates of the cost of services as a percentage of Medicare allowable values by taking a sample of high volume providers for professional

and inpatient services and determining the relationship between contracted reimbursement rates for these providers and Medicare allowed costs. This will require 4-6 weeks and will be initiated if the CDI acknowledges that this is an acceptable method to answer this question and similar methodology will be required of other carriers in conjunction with their future rate filings that are subject to SB 1163.